## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/11/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		445262	B, WING				11/10/2020	
	PROVIDER OR SUPPLIER			434	EET ADDRESS, CITY, STATE, ZIP COD 3 ASHLAND CITY HIGHWAY SHVILLE, TN 37218	DE	le l	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	was conducted by 11/10/2020. The fa compliance with 42 regulations and ha Centers for Diseas	sed Infection Control Survey the State Agency on icility was found to be in 2 CFR §483.80 infection control s implemented the CMS and the Control and Prevention ded practices to prepare for	FO	000				
BORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A_BUILDING			(X3) DATE SURVEY COMPLETED	
		445262	B, WING		11	11/10/2020	
NAME OF PROVIDER OR SUPPLIER  AHC CUMBERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE  4343 ASHLAND CITY HIGHWAY  NASHVILLE, TN 37218				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments  A COVID-19 Focused Emergency Preparedness		E 0	00			
	Survey was conduct 11/10/2020. The fact	ted by the State Agency on cility was found to be in CFR §483.73 related to					
					*1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES (X1) F

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
			A. BUILDING:		COMPLETED	
		TN1908	B. WING		11/1	0/2020
NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY :	STATE, ZIP CODE	-1	
			ILAND CITY			
AHC CUI	MBERLAND		LE, TN 3721			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
N 000	Initial Comments		N 000			
		sed Infection Control Survey				
		the State Agency on icility was found to be in				
		fection control regulations and				
		he CMS and Centers for				
		nd Prevention (CDC)				
	recommended practice 120	ctices to prepare for COVID-19				
	Homes. Total cens	0-8-6, Standards for Nursing				
	Tiomes. Total cens	45 54.				
D: 1 1	-W- O F					

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE